

		FOR OHF USE					

LL 1

**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0038455</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Alden Village Health Facility</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>267 E. Lake Street</u> <u>Bloomington</u> <u>60108</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>DuPage</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>(630) 529-3350</u> <b>Fax #</b> <u>(630) 529-9866</u>		(Type or Print Name) <u>Steven M. Kroll</u>	
<b>IDPA ID Number:</b> <u>36-3845800</u>		(Title) <u>Chief Financial Officer</u>	
<b>Date of Initial License for Current Owners:</b> <u>11/02/92</u>		(Signed) _____ (Date) _____	
<b>Type of Ownership:</b>		<b>Paid Preparer</b> (Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		(Firm Name & Address) _____	
<input type="checkbox"/> Charitable Corp.		(Telephone) <u>( )</u> Fax # ( )	
<input type="checkbox"/> Trust		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b>	
<b>IRS Exemption Code</b> _____		<b>ILLINOIS DEPARTMENT OF PUBLIC AID</b>	
<input checked="" type="checkbox"/> PROPRIETARY		201 S. Grand Avenue East	
<input type="checkbox"/> Individual		Springfield, IL 62763-0001	
<input type="checkbox"/> Partnership		Phone # (217) 782-1630	
<input checked="" type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b>			
<b>Name:</b> <u>Steven M. Kroll</u>			
<b>Telephone Number:</b> <u>(773) 286-3883</u>			

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Alden Village Health Facility# 0038455 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>109</u>	Skilled (SNF)	<u>109</u>	<u>39,785</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>109</u>	TOTALS	<u>109</u>	<u>39,785</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>36,457</u>	<u>54</u>	<u>490</u>	<u>37,001</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>36,457</u>	<u>54</u>	<u>490</u>	<u>37,001</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 93.00%

D. How many bed-hold days during this year were paid by Public Aid?

979 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)n/aF. Does the facility maintain a daily midnight census? yesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1/1/92

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/1/92 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_Medicare Intermediary n/a

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Alden Village Health Facility # 0038455 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	166,710	18,761	6,000	191,471	842	192,313		192,313		1
2	Food Purchase		552,548		552,548	(22,469)	530,079	(285,433)	244,646		2
3	Housekeeping	127,211	18,074		145,285	632	145,917		145,917		3
4	Laundry	55,557	13,834		69,391		69,391		69,391		4
5	Heat and Other Utilities			91,339	91,339	608	91,947	1,912	93,859		5
6	Maintenance	50,963		82,859	133,822	4,371	138,193	8,269	146,462		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	400,441	603,217	180,198	1,183,856	(16,016)	1,167,840	(275,253)	892,587		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			34,476	34,476		34,476		34,476		9
10	Nursing and Medical Records	2,133,878	130,401	4,271	2,268,550		2,268,550	(8,415)	2,260,135		10
10a	Therapy										10a
11	Activities	6,610	3,545	5,193	15,348		15,348		15,348		11
12	Social Services	38,977		185,927	224,904		224,904		224,904		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	2,179,465	133,946	229,867	2,543,278		2,543,278	(8,415)	2,534,863		16
	<b>C. General Administration</b>										
17	Administrative	124,288			124,288		124,288		124,288		17
18	Directors Fees										18
19	Professional Services			635,061	635,061		635,061	(593,785)	41,276		19
20	Dues, Fees, Subscriptions & Promotions			35,646	35,646	(7,886)	27,760	(21,697)	6,063		20
21	Clerical & General Office Expenses	374,916	10,441	24,668	410,025	8,143	418,168	105,292	523,460		21
22	Employee Benefits & Payroll Taxes			368,960	368,960	20,130	389,090	44,997	434,087		22
23	Inservice Training & Education										23
24	Travel and Seminar			8,599	8,599	(4,424)	4,175	8,300	12,475		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			22,889	22,889		22,889	5,539	28,428		26
27	Other (specify):* bad debt			79,689	79,689		79,689	(79,689)			27
28	<b>TOTAL General Administration</b>	499,204	10,441	1,175,512	1,685,157	15,963	1,701,120	(531,043)	1,170,077		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,079,110	747,604	1,585,577	5,412,291	(53)	5,412,238	(814,711)	4,597,527		29

\* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number Alden Village Health Facility

#0038455

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation					39,216	39,216	105,267	144,483			30
31	Amortization of Pre-Op. & Org.							7,600	7,600			31
32	Interest			155,481	155,481		155,481	271,976	427,457			32
33	Real Estate Taxes							50,565	50,565			33
34	Rent-Facility & Grounds			640,824	640,824		640,824	(640,387)	437			34
35	Rent-Equipment & Vehicles			8,455	8,455	3,625	12,080	12,349	24,429			35
36	Other (specify):* morg insur			42,788	42,788	(42,788)		29,230	29,230			36
37	<b>TOTAL Ownership</b>			847,548	847,548	53	847,601	(163,400)	684,201			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		12,850	97,440	110,290		110,290	5,145	115,435			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			400,362	400,362		400,362		400,362			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		12,850	497,802	510,652		510,652	5,145	515,797			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	3,079,110	760,454	2,930,927	6,770,491		6,770,491	(972,966)	5,797,525			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(19,168)	30		9
10	Interest and Other Investment Income	(264)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(131)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(357)	32		18
19	Entertainment				19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(79,689)	27		24
25	Fund Raising, Advertising and Promotional	(11,905)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (111,564)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(692,919)		34
35	Other- Attach Schedule	(168,483)	pg 5a	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (861,402)		36
37	<b>(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (972,966)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

Alden Village Health Facility

ID# 0038455

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	BEAUTY/BARBER INCOME	\$ (559)	21	1
2	MISCELLANEOUS INCOME	(3,316)	21	2
3	PAC FEES	(523)	20	3
4	MARKETING MGT FEE	(9,498)	20	4
5	Increase def. Maint. Cost to correct amt on pg 22	2,005	6	5
6	Intercompany interest in gl 7031	(155,124)	32	6
7	Back out utility late fee	(465)	5	7
8	legal fees for collections	(1,002)	21	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(168,483)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(131)	0	0	(285,302)	0	0	0	0	0	0	0	(285,433)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(465)	0	2,377	0	0	0	0	0	0	0	0	1,912	5
6	Maintenance	2,005	0	6,332	0	0	0	(68)	0	0	0	0	8,269	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>1,408</b>	<b>0</b>	<b>8,709</b>	<b>(285,302)</b>	<b>0</b>	<b>0</b>	<b>(68)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(275,253)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(6,872)	0	(1,543)	0	0	0	0	0	(8,415)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(6,872)</b>	<b>0</b>	<b>(1,543)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(8,415)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	4,430	(598,215)	0	0	0	0	0	0	0	0	(593,785)	19
20	Fees, Subscriptions & Promotions	(21,976)	0	279	0	0	0	0	0	0	0	0	(21,697)	20
21	Clerical & General Office Expenses	(4,877)	0	17,314	92,623	0	232	0	0	0	0	0	105,292	21
22	Employee Benefits & Payroll Taxes	0	0	44,960	0	0	37	0	0	0	0	0	44,997	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	8,300	0	0	0	0	0	0	0	0	8,300	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	5,539	0	0	0	0	0	0	0	0	0	5,539	26
27	Other (specify):*	(79,689)	0	0	0	0	0	0	0	0	0	0	(79,689)	27
28	<b>TOTAL General Administration</b>	<b>(106,542)</b>	<b>9,969</b>	<b>(527,362)</b>	<b>92,623</b>	<b>0</b>	<b>269</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(531,043)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(105,134)</b>	<b>9,969</b>	<b>(518,653)</b>	<b>(199,551)</b>	<b>0</b>	<b>(1,274)</b>	<b>(68)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(814,711)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455

Report Period Beginning:

01/01/2002 Ending:

12/31/2002

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	(19,168)	111,822	12,564	0	0	49	0	0	0	0	0	105,267 30
31	Amortization of Pre-Op. & Org.	0	6,549	1,039	0	12	0	0	0	0	0	0	7,600 31
32	Interest	(155,745)	395,108	32,406	0	168	39	0	0	0	0	0	271,976 32
33	Real Estate Taxes	0	47,771	2,782	0	0	12	0	0	0	0	0	50,565 33
34	Rent-Facility & Grounds	0	(640,824)	437	0	0	0	0	0	0	0	0	(640,387) 34
35	Rent-Equipment & Vehicles	0	0	12,349	0	0	0	0	0	0	0	0	12,349 35
36	Other (specify):*	0	29,230	0	0	0	0	0	0	0	0	0	29,230 36
37	<b>TOTAL Ownership</b>	<b>(174,913)</b>	<b>(50,344)</b>	<b>61,577</b>	<b>0</b>	<b>180</b>	<b>100</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(163,400) 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	5,156	(11)	0	0	0	0	0	5,145 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,156</b>	<b>(11)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5,145 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(280,047)</b>	<b>(40,375)</b>	<b>(457,076)</b>	<b>(199,551)</b>	<b>5,336</b>	<b>(1,185)</b>	<b>(68)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(972,966) 45</b>

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services, Inc	100	See pg 6k		See pg 6k		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent income	\$ 640,824	Village II, Inc.	100.00%	\$	\$ (640,824)
2	V	32 Investment income-RR	3,068	Village II, Inc.			(3,068)
3	V	32 Investment income-misc	22,769	Village II, Inc.			(22,769)
4	V	33 Real estate tax		Village II, Inc.		47,771	47,771
5	V	26 Prop & liab insurance		Village II, Inc.		5,539	5,539
6	V	32 Interest on mortg note		Village II, Inc.		420,945	420,945
7	V	36 Mort. Insur. Premium		Village II, Inc.		29,230	29,230
8	V	19 Miscell. Financ. Exps		Village II, Inc.		4,430	4,430
9	V	30 Depreciation		Village II, Inc.		111,822	111,822
10	V	31 Amortization		Village II, Inc.		6,549	6,549
11	V						
12	V						
13	V						
14	Total		\$ 666,661			\$ 626,286	\$ * (40,375)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 employee benefits	\$	Alden Management Services, Inc.	100.00%	\$ 44,960	\$ 44,960	15
16	V	19 profess. Fees	605,858	Alden Management Services, Inc.		7,643	(598,215)	16
17	V	21 g & a		Alden Management Services, Inc.		17,314	17,314	17
18	V	5 utilities		Alden Management Services, Inc.		2,377	2,377	18
19	V	6 maintenance		Alden Management Services, Inc.		6,332	6,332	19
20	V	24 auto/travel		Alden Management Services, Inc.		8,300	8,300	20
21	V	20 subscriptions/etc		Alden Management Services, Inc.		279	279	21
22	V	30 depreciation		Alden Management Services, Inc.		12,564	12,564	22
23	V	31 amortization		Alden Management Services, Inc.		1,039	1,039	23
24	V	33 real estate tax		Alden Management Services, Inc.		2,782	2,782	24
25	V	34 rent		Alden Management Services, Inc.		437	437	25
26	V	35 rent-equip/vehicles		Alden Management Services, Inc.		12,349	12,349	26
27	V	32 interest		Alden Management Services, Inc.		32,406	32,406	27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 605,858			\$ 148,782	\$ * (457,076)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 tube feeding	\$ 426,806	Pyramid Health Care Services	100.00%	\$ 141,504	\$ (285,302)	15
16	V	10 nursing supplies	12,118	Pyramid Health Care Services		5,246	(6,872)	16
17	V	21 gen'l & admin costs		Pyramid Health Care Services		92,623	92,623	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 438,924			\$ 239,373	\$ * (199,551)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger		5 Cost to Related Organization		6	7	8 Difference:	
Schedule V			Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	therapy	\$ 94,286	Community Physical Therapy	100.00%	\$ 99,442	\$ 5,156	15	
16	V	32	interest		Community Physical Therapy		168	168	16	
17	V	31	amortization		Community Physical Therapy		12	12	17	
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$ 94,286			\$ 99,622	\$ * 5,336	39	

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455

Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	39 Drugs	\$	Forum Extended Care II	100.00%	\$	\$	15
16	V	10 House stock	6,610	Forum Extended Care II		5,067	(1,543)	16
17	V	39 IV	48	Forum Extended Care II		37	(11)	17
18	V	22 Employee benefits		Forum Extended Care II		37	37	18
19	V	21 G & A		Forum Extended Care II		232	232	19
20	V	32 Interest		Forum Extended Care II		39	39	20
21	V	33 Real estate taxes		Forum Extended Care II		12	12	21
22	V	30 Depreciation		Forum Extended Care II		49	49	22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 6,658			\$ 5,473	\$ * (1,185)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	6 maintenance expense	\$ 22,752	Alden Bennett Construction	100.00%	\$ 22,684	\$ (68)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 22,752			\$ 22,684	\$ *	(68) 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Alden Village Health Facility # 0038455 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd A. Schlossberg	President/CFO	Management	100% A	349,924	1.464	3.66	salary	\$ 13,288	17-1	1
2	Lauren Magnusson	Clinical Coordinator	Management	B	88,357	1.464	3.66	salary	3,355	17-1	2
3	Terry Magnusson	Maint. Superv.	Management	C	82,677	1.464	3.66	salary	3,140	17-1	3
4											4
5											5
6	A. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										6
7	B. Lauren Magnusson is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator.										7
8	C. Terry Magnusson is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 19,783		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Village Health Facility # 0038455 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.  
 Street Address 4200 W. Peterson Ave.  
 City / State / Zip Code Chicago, IL 60646  
 Phone Number ( 773 ) 286-3883  
 Fax Number ( 773 ) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<a href="#">see page 8A (also on page 6A)</a>				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Cambridge	x		mortgage	\$39,067.00	4/99	\$ 5,983,300	\$ 5,824,365	4/34	7.2000	\$ 420,945	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	related party - Ams	x		working capital	none					varies	32,406	6	
7	related party - FECII	X		working capital							39	7	
8	related party - CPT	X		working capital							168	8	
9	TOTAL Facility Related					\$39,067.00		\$ 5,983,300	\$ 5,824,365			\$ 453,558	9
	B. Non-Facility Related*												
10	interest income on repl res	x		Vlg II, replac reserv income							(25,837)	10	
11	miscell interest income		x	Vlg Corp: gl 4646							(264)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related							\$	\$			\$ (26,101)	14
15	TOTALS (line 9+line14)							\$ 5,983,300	\$ 5,824,365			\$ 427,457	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 29,230 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

## B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	46,525	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	46,451	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(74)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	47,845	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	47,771	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:	1997	43,638	8		
	1998	44,481	9		
	1999	44,594	10		
	2000	44,695	11		
	2001	46,451	12		
Estimate based on a 3% increase over prior yr bill.					
				13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

## NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Alden Village Health Facility COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0038455

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE 773-286-6622 FAX #: 773 286-3743

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>02-14-107-028</u>	<u>Nursing home</u>	\$ <u>43,352.82</u>	\$ <u>43,352.82</u>
2. <u>02-14-107-027</u>	<u>Nursing home</u>	\$ <u>3,098.20</u>	\$ <u>3,098.20</u>
3. _____	<u>Related Party - Alden Management</u>	\$ <u>76,052.00</u>	\$ <u>2,782.00</u>
4. _____	<u>Related Party - Forum</u>	\$ <u>8,608.00</u>	\$ <u>12.00</u>
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>131,111.02</u></u>	\$ <u><u>49,245.02</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

12/31/2002

	1	2	3	4
	Use	Square Feet	Year Acquired	Cost
1	Building		1992	\$ 135,758
2				
3	TOTALS			\$ 135,758

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	related party-Ams				\$	\$		\$	\$	4
5	related party-Forum									5
6	109		1992	1973	639,042		30	21,301	21,301	623,002
7			1984	1984	706,283	87,555	15	47,086	(40,469)	840,786
8										8
	<b>Improvement Type**</b>									
9	Repair Heater pump, replace temp controller		1992		2,131	195	10	195		2,131
10	Water heater moyor;valve repair		1993		9,288	409	5-15	409		8,707
11	Carpentry work, water heater repair		1994		63,064	2,937	3-15	2,937		46,099
12	Fire alarm repairs; brickwork; install circuits		1995		185,123	8,142	3-25	8,142		85,117
13	Village construction		1996		14,046	562	25	562		4,354
14	Install fire door		1996		2,977	198	15	198		1,356
15	Replace compressor		1997		1,825	183	5	183		1,825
16	Roof patching		1998		1,700	170	10	170		793
17	Replace condensing unit		1998		4,810	321	15	321		1,443
18	install damper motor & detector		1998		2,104	140	15	140		596
19	Replace furnace equipment		1999		1,827	122	15	122		487
20	install automatic door		1999		8,107	811	10	811		2,702
21	Install display and digital phones		2000		1,726	173	10	173		417
22	Replace HVAC burners		2000		1,607	536	3	536		1,607
23	Replace 5 ton condensing unit		2000		1,950	390	5	390		1,040
24	Install 100 amp disconnect and cable		2000		1,920	384	5	384		1,024
25	Roof repair		2000		1,583	317	5	317		686
26	Door Alarms		2001		19,015	1,902	10	1,902		2,852
27	Display phone and digital phone		2001		1,609	161	10	161		308
28	ABC (misc. repairs)		2002		2,362	472	5	472		472
29	Capps Plumbing (gas regulators for main gas to building)		2002		4,375	401	10	401		401
30	GT Mechanical (semi - hermetic compressor on RTU)		2002		5,350	312	10	312		312
31	ABC (wall mounted eye wash)		2002		2,507	104	10	104		104
32	ABC (misc. repairs)		2002		1,800	150	5	150		150
33										33
34										34
35										35
36										36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,688,130	\$ 107,047		\$ 87,879	\$ (19,168)	\$ 1,628,774	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	19,335		20			19,334	4
5	Leasehold Improvement-Remodeling	1980	1,208		10			1,208	5
6	Leasehold Improvement-Remodeling	1986	645		5			645	6
7	Leasehold Improvement-Remodeling	1990	404		5			404	7
8	Leasehold Improvement-Remodeling	1991	94		5			94	8
9	Leasehold Improvement-Remodeling	1993	8,304	830	10	830		8,304	9
10	Leasehold Improvement-Remodeling	1993	6,504	469	9.7	469		6,504	10
11	Leasehold Improvement-sign	1994	261	22	12	22		174	11
12	Leasehold Improvement-dryvit	1995	443	44	10	44		310	12
13	Leasehold Improvement-new ac	1999	723	48	15	48		145	13
14	Leasehold Improvement-roof	1985	972	52	19	52		922	14
15	Leasehold Improvement-roof	1994	863	58	15	58		518	15
16	Leasehold Improvement-roof	1997	819	55	15	55		328	16
17	Leasehold Improvement-roof	1998	1,390	93	15	93		464	17
18	Leasehold Improvement-parking lot asphalt	2000	111	11	10	11		33	18
19	Leasehold Improvement-hallway lighting	2001	155	16	10	16		32	19
20	Leasehold Improvement-DAI	2001	195	19	10	19		38	20
21	Leasehold Improvement-bathrooms	2002	687	69	10	69		69	21
22	Leasehold Improvement-Remodeling	2002	98	20	5	20		20	22
23	Related Party-AMS:								23
24	Leasehold Improvement-Remodeling	1993	4,266		7			4,266	24
25	Leasehold Improvement-Remodeling	1994	2,112		7			2,112	25
26	Leasehold Improvement-Remodeling	2002	5,221		7				26
27									27
28									28
29									29
30									30
31									31
32	Related Party-Forum Ext. Care	1999	1,764	9	40	9		183	32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,744,704	\$ 108,861		\$ 89,693	\$ (19,168)	\$ 1,674,881	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 622,084	\$ 48,128	\$ 48,128	\$	varies	\$ 261,243	71
72	Current Year Purchases	25,442	1,692	1,692		varies	1,693	72
73	Fully Depreciated Assets	78,555	1,179	1,179		varies	78,555	73
74								74
75	TOTALS	\$ 726,081	\$ 50,999	\$ 50,999	\$		\$ 341,491	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car,engine,van/bus	dodge	'98-'02	\$ 12,336	\$ 3,791	\$ 3,791	\$	3	\$ 9,992	76
77										77
78										78
79										79
80	TOTALS			\$ 12,336	\$ 3,791	\$ 3,791	\$		\$ 9,992	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,618,880	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 163,651	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 144,483	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (19,168)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,026,364	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$ n/a	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: related party- cost is backed out.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☒ YES ☒ NO

16. Rental Amount for movable equipment: \$ 8,455

Description: copy machine

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	staff transport.		\$ 725.00	\$ 3,625	17
18	related party		1,029.00	12,349	18
19					19
20					20
21	TOTAL		\$ 1,754.00	\$ 15,974	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ \_\_\_\_\_

13. /2004 \$ \_\_\_\_\_

14. /2005 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.		IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____
		HOURS PER AIDE _____	

Skilled nurses on site

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 18,587
2	Licensed Speech and Language Development Therapist	39-3	hrs			19,914				19,914	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39-3	hrs			55,152				55,152	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	see pg 16a	# of prescrpts				3,777			3,777	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10			hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):	see pg 16a					18,006			18,006	13
14	TOTAL			\$		\$ 93,652	\$ 21,783		\$	115,435	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	7,207	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 6,528 )	1,836,369	1,836,369	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	4,186	20,246	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>escrows</u>	177,576	1,537,976	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,018,131	\$ 3,401,798	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		580,000	13
14	Buildings, at Historical Cost		3,414,649	14
15	Leasehold Improvements, at Historical Cost	471,181	471,181	15
16	Equipment, at Historical Cost	269,516	633,516	16
17	Accumulated Depreciation (book methods)	(451,012)	(932,155)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>financing fees, net of amort</u>		205,213	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 289,686	\$ 4,372,405	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,307,816	\$ 7,774,202	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 553,022	\$ 553,022	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	202,175	202,175	30
31	Accrued Taxes Payable (excluding real estate taxes)	31,662	31,662	31
32	Accrued Real Estate Taxes(Sch.IX-B)		47,845	32
33	Accrued Interest Payable		34,946	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>various accr expense/s.t. portion mortg.</u>	16,026	74,412	36
37	<u>resident liabilities</u>	43,462	43,462	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 846,347	\$ 987,524	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,773,252	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<u>due to affiliates</u>	80,833	108,778	43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 80,833	\$ 5,882,030	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 927,180	\$ 6,869,554	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,380,636	\$ 904,648	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,307,816	\$ 7,774,202	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 640,257	1
2	Restatements (describe):		2
3	adjustments made after report submitted- no effect on		3
4	allowable costs (bad debts/etc).	3,226	4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 643,483	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	737,153	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ 737,153	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 1,380,636	24 *

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1		Amount	
<b>Revenue</b>			
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 7,126,506	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,126,506	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	559	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 559	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	264	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 264	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	misc income- backed out of line 21 on pg 5a	3,316	28
28a	w/off of old payables	1,474	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 4,790	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,132,119	30

2		Amount	
<b>Expenses</b>			
<b>A. Operating Expenses</b>			
31	General Services	1,183,856	31
32	Health Care	2,543,278	32
33	General Administration	1,685,157	33
<b>B. Capital Expense</b>			
34	Ownership	847,548	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	110,290	35
36	Provider Participation Fee	400,362	36
<b>D. Other Expenses (specify):</b>			
37	Related party salary allocations	(375,525)	37
38	located in column 1 (on pg 3 & 4)		38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,394,966	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	737,153	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 737,153	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

## STATE OF ILLINOIS

Page 20

Facility Name &amp; ID Number Alden Village Health Facility

# 0038455

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,048	2,128	\$ 69,472	\$ 32.65	1
2	Assistant Director of Nursing	944	960	13,358	13.91	2
3	Registered Nurses	21,133	22,402	574,831	25.66	3
4	Licensed Practical Nurses	9,827	10,509	225,258	21.43	4
5	Nurse Aides & Orderlies	116,623	119,700	1,204,420	10.06	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,520	2,608	36,298	13.92	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	632	640	9,288	14.51	11
12	Dietician					12
13	Food Service Supervisor	1,840	2,080	33,699	16.20	13
14	Head Cook	3,783	4,201	33,603	8.00	14
15	Cook Helpers/Assistants	12,558	13,627	99,409	7.30	15
16	Dishwashers					16
17	Maintenance Workers	1,880	2,080	38,424	18.47	17
18	Housekeepers	12,131	13,043	127,212	9.75	18
19	Laundry	5,516	5,995	55,557	9.27	19
20	Administrator					20
21	Assistant Administrator	232	240	7,110	29.63	21
22	Other Administrative	2,990	3,230	86,607	26.81	22
23	Office Manager					23
24	Clerical	3,868	4,151	44,120	10.63	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	3,120	3,400	46,540	13.69	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	201,645	210,994	\$ 2,705,206 *	\$ 12.82	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	\$ 6,000	1	35
36	Medical Director	monthly	34,476	9	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,616	10	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	66	3,641	11-3	44
45	Social Service Consultant	29	1,552	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	95	\$ 48,285		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries				Ownership		D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%	Amount	Description		Amount	Description		Amount	
DiPaolo/Glantz	administrator	0	\$	Workers' Compensation Insurance	\$	57,564	IDPH License Fee	\$		
Palazzo, J	administrator	0		Unemployment Compensation Insurance		38,773	Advertising: Employee Recruitment			
Taylor, G	administrator	0	66,474	FICA Taxes		199,526	Health Care Worker Background Check			
Weber, K	administrator	0		Employee Health Insurance		63,306	(Indicate # of checks performed _____)			
executives/assist admin	amin.	0	57,813	Employee Meals		22,469				
				Illinois Municipal Retirement Fund (IMRF)*			surety bond fees		944	
				dental/life insur		1,709	II Health Care Ass		4,840	
				employee relations/background/drug checks		2,922	related party-Ams		279	
				vaccinations		2,822				
				Related party - FECII- page 6c		37				
				Related party - Ams		44,960				
						0				

\* Attach copy of IMRF notifications

**\*\*See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
 (See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Wash Condenser	5/93	\$ 3,238	10	\$ 324	\$ 324	\$ 324	\$ 324	\$ 324	\$ 108	\$	\$	\$
2	Circulator pump	11/94	2,100	10	210	210	210	210	210	210	175		
3	Compressor A/C	11/94	2,191	15	146	146	146	146	146	146	146	146	146
4	Circulator Pump	1/95	1,621	10	162	162	162	162	162	162			
5	Relocating water pipe	7/95	1,908	15	127	127	127	127	127	127	127	127	127
6	Rooftop repair	9/96	3,545	10	354	354	354	354	354	354	354	354	354
7	Repair A/C	6/98	3,650	3	1,217	1,217	507						
8	Replace blowers	10/98	2,620	3	873	873	655						
9	replace blowers	10/98	2,115	3	705	705	529						
10	Thermometor on heater	8/99	1,502	3	209	501	501	292					
11													
12	Reapir water main and tie	5/00	1,572	3		349	524	524	175				
13	Repair CAT equip	11/00	1,855	3		103	618	618	515				
14	General repairs	7/01	1,550	3			215	517	517	302			
15	RPZ reapir and cert	7/01	2,781	3			386	927	927	541			
16	General repairs	9/01	1,766	3			147	589	589	441			
17	General Maintenance	11/01	2,362	3			66	787	787	721			
18	no new items for 2002												
19													
20	TOTALS		\$ 36,376		\$ 4,327	\$ 5,071	\$ 5,471	\$ 5,577	\$ 4,833	\$ 3,112	\$ 802	\$ 627	\$ 627

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN, LPN, NA) represented by a union? no
- (2) Are there any dues to nursing home associations included on the cost report? yes  
If YES, give association name and amount. IL Healthcare Assoc. \$4,840
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 58,558 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 400,362  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 22,469 Has any meal income been offset against related costs? no Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? no  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? n/a  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a  
**g. Does the facility transport residents to and from day training? no**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? yes  
Firm Name: BDO Seidman, LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. not yet completed
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes  
Attach invoices and a summary of services for all architect and appraisal fees.